	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155066	B. WING		07/11/2012
NAME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
FDGEW/	ATER WOODS			MADISON AVE RSON, IN 46011	
				T	975
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
	This visit was	for the Annual	F0000		
	Recertification	and State Licensure			
	survey.				
	-	July 2, 3, 5, 6, 9, 10			
	and 11, 2012				
	Egoility symbo	or: 000026			
	Facility number				
	AIM number:				
	Alivi Hullibel.	100274020			
	Survey team:				
	Toni Maley, B	SW TC			
	Tammy Alley,				
		RN (7/2, 3, 5, 6/12)			
	,	(, -, -, - ,			
	Census bed ty	rpe:			
	SNF/NF: 76				
	Total: 76				
	Census payor	type:			
	Medicare: 14				
	Medicaid: 51				
	Other: 11				
	Total: 76				
	Those deficien	acian maffant at -t-			
		ncies reflect state			
	IAC 16.2.	in accordance with 410			
	IAC 10.2.				
	 Quality review	completed on July 16,			
	2012 by Bev F	•			
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000026

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 11/2012			
	ROVIDER OR SUPPLIE TER WOODS	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011						
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 2 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155066	B. WING	<u> </u>		07/11/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0157 SS=E	A facility must im resident; consult and if known, not representative or member when the resident which the potential for rintervention; a significantly (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative or when there is a classing as change in resident and paragraph (b)(1). The facility must update the addresserver is the sident and the	NE/ROOM, ETC) Immediately inform the with the resident's physician; tify the resident's legal r an interested family were is an accident involving the results in injury and has requiring physician gnificant change in the ral, mental, or psychosocial reforation in health, mental, restatus in either life litions or clinical r need to alter treatment ra need to discontinue an reatment due to adverse or to commence a new form reatment due to adverse or to commence a new form reatment from the facility as 3.12(a). also promptly notify the nown, the resident's legal r interested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in					
	family member. Based on recordinterview, the father physician was medications we		F015	7	A. The Physicians of residents 94 7, 60, and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure that		08/06/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 3 of 46

i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155066	B. WIN			07/11/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	MADISON AVE		
EDCEW	ATER WOODS						
EDGEW	ATER WOODS			ANDER	RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed for m	edication			all current medications were		
	administration	in a sample of 10.			available for administration.		
	(Resident # 94, 7, 60, and 75)				B. All residents have the		
	(11001001111111111111111111111111111111	, , , , , , , , , , , , , , , , , , , ,			potential to be affected by this		
	Findings includ	la.			deficient practice. The facility		
	Findings includ	le.			completed an audit of the MAR for		
					the residents who reside in the		
	1. The record	for Resident # 94 was			facility to assure that all current		
	The May 2012 Medication Administration Record (MAR)				medications and dosages were		
					available for administration.		
					C. Inservice training was		
					provided by the SDC on 7-17-12 on		
					the policy and procedure for		
	indicated Pepcid 20 milligrams (mg)				handling "medication not		
		ole 5/17-5/21 from the			available/no supply" and		
	pharmacy.				documentation including but not		
					limited to: notification of physician,		
	The nursing no	ites between the above			notification of resident/family,		
	dates did not a	ddress the medication			notification of DNS/designee, and		
	being unavaila	ble or that the			communication with the pharmacy.		
	physician was				In the event that medication is not		
	priyololari was	notinea.			available licensed staff will attempt		
	A -1 -1:4: 1 : £				to locate the medication, they will		
		mation was requested			check the Emergency Drug Kit (EDK))	
		ant Director of Nursing			for the med. If still unavailable,		
	(ADON) on 7/1	0/12 at 10:35 a.m.,			licensed staff will then contact the		
	regarding phys	ician notification of			pharmacy for stat delivery. Staff wi	II	
	medication una				contact the physician, the		
		•			resident/family, and the		
	During intervie	w on 7/10/12 at 4 p.m.,			DNS/designee. Licensed staff will		
		cated she was unable			complete a Medication/Treatment		
					Error Report to document and track	(
	1	formation regarding			the event. MAR audits will be		
	' '	cation of the Pepcid			conducted daily by the		
	not being avail	able for administration.			DNS/designee to assure meds are		
					available and physicians are notified		
	2. The record	for Resident # 7 was			Those audits will be done daily for		
	reviewed on 7/	6/12 at 8:46 a.m.			consecutive weeks utilizing the MAI		
					Checklist. Those audits will continu	e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 4 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O	COMPLETED	
155066 B. WING	07/11/2012	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 1809 N MADISON AVE		
EDGEWATER WOODS ANDERSON, IN 46011		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
The June 2012 MAR indicated to be done weekly for 4 additional		
Hydrochlorathiazide (HCTZ) 25 mg weeks, then monthly for 2 months,		
was not available on June 20, 21 and		
22 for administration. D. The MAR CQI tool will be		
completed weekly for 4 weeks, then		
The nursing notes between 6/20-6/22 monthly for 2 additional months,		
did not address the HCTZ not being then quarterly thereafter. The results of both audits and the		
available or that the physician was Medication/Treatment Error Reports	,	
notified of the missed doses. will be added to the agenda of the		
monthly CQI meeting for review.		
The COI team will greate a further		
Additional information was requested plan of action if further issues arise		
from the Assistant Director of Nursing or a threshold score of 90% is not		
(ADON) on 7/10/12 at 10:35 a.m.,		
regarding physician notification of 8-6-2012		
medication unavailability.		
During interview on 7/10/12 at 4 p.m.,		
the ADON indicated she was unable		
to locate any information regarding		
physician notification of the HCTZ		
unavailability for administration.		
unavaliability for autilinistration.		
O. The meant for Desident # 00 and		
3. The record for Resident # 60 was		
reviewed on 7/10/12 at 8:20 a.m.		
The April 2012 MAR indicated		
between 4/6-4/20, Risperdal 0.25 mg		
and Ambien 5 mg was not available		
for administration.		
The May 2012 MAR indicated		
between 5/1-5/6, Zegerid 40/100 mg		
was not available for administration.		
was not available for authinistration.		
The June 2012 MAR between		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 5 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155066	A. BUI B. WIN			07/11/2	2012
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	3			MADISON AVE		
FDGFW/	ATER WOODS				SON, IN 46011		
				<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		<u> </u>	-	TAG	DLI ICILIACI)		DATE
		cated Zanaflex 5 mg					
	was not availal	ole.					
	Additional information was requested						
	from the Assist	tant Director of Nursing					
	(ADON) on 7/1	0/12 at 10:35 a.m.,					
	regarding phys	sician notification of					
	medication una						
		·					
	During intervie	w on 7/10/12 at 4 p.m.,					
	the ADON indicated she was unable to locate any information regarding						
	1	cation of the above					
	medications ur						
	administration.	•					
	aummistration.						
	During on inter	riou with LDN #10 on					
		view with LPN #10 on					
		p.m., she indicated if					
		as circled on the MAR,					
		s to be noted on the					
		R. If the medication					
		e from the pharmacy,					
	the pharmacy	was to be notified. She					
	indicated the p	hysician was to be					
	notified when a	medication is not					
	given. She als	o indicated the facility					
	had some diffic	_					
	mediations tim	· ·					
		- ,					
	Quality Improv	ement information					
	Quality Improvement information dated 3/23/12 was provided by the						
		of Nursing) on 7/11/12					
	,	<u>.</u>					
	· ·	hich indicated there					
		es and circles on the					
	MARS. An ins	ervice dated 5/8/12				l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 6 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155066	B. WIN	G		07/11/	2012
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1809 N	MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re I	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ou circle meds					
	(medication) on the MAR, you must						
	notify the MD (physician) and					
	document on the back of the MAR the reason for holding the med" 4.) Resident #75's record was reviewed on 7/10/12 at 12:53 p.m.						
		•					
	Resident #75's current diagnoses						
	included, but were not limited to, a						
	history of CVA (cerebral vascular						
		e), dementia with					
		iety, depression,					
	Alzheimer's dis	•					
		us, bipolar disorder,					
		geal reflux disease,					
	, ,	er and mood disorder.					
	Seizure disorde	er and mood disorder.					
	 Resident #75 h	nad a current care plan					
		regarding pain or					
	l ·	is problem originated					
		proach to this problem					
		ter medications as					
		itel medications as					
	ordered.						
	A review of De	aidant #75'a					
	A review of Re						
		ministration Record for					
	• • •	ne and May 2012 found					
		ere not available on the					
	following dates	:					
	- > 0/0/40 1/11	(
	I	am (a pain medication)					
	not available, p	harmacy aware.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 7 of 46

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		NSTRUCTION 00	(X3) DATE COMPL	ETED
		155066	B. WING			07/11/	2012
	PROVIDER OR SUPPLIER ATER WOODS			1809 N I	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN 46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
		intac (a medication to ch acid or stomach lable					
	c.) 6/27/12-Za	ntac not available					
	· '	•					
	e.) 5/8/12, 8:00 available "phar	a.m Pepcid not macy notified"					
	any documenta physician being lack of availabl possible need t as a substitute alternate treatn	clinical record lacked ation of the resident's protified regarding the emedication and the consideration or ment during the time ation was unavailable.					
	Director of Nurse regarding Residual being notified re availability in Madditional infor	2, 12:55 p.m., administrator and sing were questioned dent #75's physician egarding medication lay and June 2012. No mation was provided exit on 7/11/12 at 3:45					
	3.1-5(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 8 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 11/2012			
	ROVIDER OR SUPPLIE TER WOODS	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011						
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 9 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155066	A. BUII			07/11/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
	ATED MOODS				MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	483.13(c)(1)(ii)-(
SS=D	INVESTIGATE/F						
	ALLEGATIONS/						
	The facility must not employ individuals who						
		I guilty of abusing,					
	•	streating residents by a court					
	of law; or have had a finding entered into the State nurse aide registry concerning abuse,						
		ment of residents or					
	_	of their property; and report					
		t has of actions by a court of					
	,	mployee, which would					
	_	s for service as a nurse aide					
		taff to the State nurse aide					
	registry or licens						
	The facility must	ensure that all alleged					
		ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property are					
		ately to the administrator of					
	_	other officials in accordance					
		rough established					
	certification ager	uding to the State survey and					
	Certification agei	icy).					
	The facility must	have evidence that all					
	-	s are thoroughly investigated,					
	_	at further potential abuse					
	•	gation is in progress.					
	•	, ,					
	The results of all	investigations must be					
	•	dministrator or his					
		esentative and to other					
		dance with State law					
		State survey and certification					
		working days of the incident,					
	•	d violation is verified					
		ective action must be taken.	F02	2.5			00/06/2012
	Based on inter	view and record	F02	25	A. The facility ensured resident		08/06/2012
	review, the faci	lity failed to promptly			82 was free from abuse. The		
		•			allegation made by resident 82 was		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

)26 If co

If continuation sheet Page 10 of 46

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155066	A. BUII B. WIN			07/11/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MADISON AVE		
EDGEWA	ATER WOODS				RSON, IN 46011		
LDGLVV	TER WOODS			ANDLIV			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	na State Department			reported 6-25-12.		
	of Health of an allegation of abuse for				B. All residents have the		
	1 of 1 resident who met the criteria for				potential to be affected by this		
	abuse investiga	ation. (Resident #82)			deficient practice. The facility	_	
					ensured that all allegations of abuse	e	
					were reported according to policy.		
	Findings Include:				QIS "Abuse" section questions were asked of all residents in the facility	=	
	i manigo molado.				6-25-12.		
					C. All staff received inservice		
	1) Desident#				training provided by SDC on		
	1.) Resident #82's record was reviewed on 7/10/12 at 1:17 p.m.				American Senior Community's Abus	se	
	reviewed on 7/	10/12 at 1:17 p.m.			and Prohibition Policy on 7-17-12		
					including reporting to ISDH.		
	Resident #82's	current diagnoses			Residents who have alleged abuse		
	included, but w	ere not limited to,			will have a complete investigation		
	mental retarda	tion, psychotic			initiated. This investigation will		
	disorder, hallud	cinations and			include interviews with staff, other		
	depressive disc				residents, and family members if		
					necessary. Staff report allegations		
	Resident #82 h	nad a 6/20/12, 2:12			of abuse to their immediate		
		Progress Note			supervisor. The Executive Director		
		indicated "Resident			and/or Director of Nursing Services		
					is notified immediately and		
		hite married men came			Executive Director reviews to assur	e	
	1	vesterday at 3p (3:00			reporting to all the appropriate		
	l · · · · ·	hed her. One of the			agencies is initiated per ISDH		
	men was old th				guidelines. All allegations of Abuse Neglect, and Misappropriation will	,	
	younger. Resi	dent was reassured			also be reviewed by the IDT to		
	that she was sa	afe."			assure proper reporting is		
					completed. Physician and Family a	re	
	6/22/12, 4:26 p	o.m., R.P.N., "IDT			notified for all allegations of abuse.		
		ary Team]: SSD [Social			D. The Abuse Prohibition and		
	Services Director], DNS [Director of				Investigation CQI tool will be utilize	d	
	Nursing Services], ADNS [Assistant				by facility to monitor compliance to		
	_	sing] and LPD [Life			the Abuse Prohibition policy weekly		
		•.			for 4 weeks, then monthly for 3		
	Path Director]:				months, and quarterly thereafter.		
	i approached by	Hillcroft [Provider for					

i î		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155066	B. WIN			07/11/	2012
			D. 11 II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			MADISON AVE		
EDGEWA	ATER WOODS				SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	services to dev	elopmentally disabled			The QIS "Abuse" section questions	•	
		presentative on 6/21/12			will be utilized to assure compliance	!	
		ident made statement			weekly for 4 weeks, then monthly		
	_				for 2 months and quarterly		
		e made inappropriate			thereafter. The results of the Abuse		
		er and resident felt like			Prohibition and Investigation CQI		
		harm herselfThe			tool and the QIS questions will be		
		ed it was an older fat			added to the agenda of the monthly	,	
	man with white	hair. This writer			CQI meeting for review. The CQI		
	asked the resid	dent if this was the			team will create a further plan of		
	same incident that we talked about				action if further issues arise or a		
	yesterday. Resident stated yes.				threshold score of 100% is not		
	Resident stated she is familiar with				achieved on Abuse Prohibition and		
		e facility and it is not a			Investigation CQI tool.		
		•			E. 8-6-2012		
		facilitybelieved					
	male to have w						
		epartment, however					
	the description	of such man is not					
	consistent with	any male working at					
	this facility."						
	·						
		o.m., R.P.N.,"received					
		sent to ISDH [Indiana					
	State Departme	ent of Health] from					
	OBRA provide	r [Hillcroft]this SW					
] interviewed resident					
	-	reported by OBRA					
		sident,'some guys					
	-	om.''They took off my					
	1						
		I it to me.'They had					
	sex.''I told her. And she told the						
	nurse.'"						
	2) Doubouref	a dagumant titlad					
	1	a document titled					
		Event-Verification of					
	Immediate Pro	tective Measures					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 12 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155066	B. WIN	G		07/11/2	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			MADISON AVE		
EDGEW <i>A</i>	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	cated the report was					
		22/12, at 2:52 p.m. to					
		Director by the Bureau					
	of Developmen						
	,	S). The document					
	indicated:						
	_ ·	reported to [Hillcroft					
	·	that she had been					
		day (6/19/12) around					
		rnoon. She said the					
		vas an employee with					
	•	I described him as a					
		n gray hair who was					
	•	n shirt and blue					
	·	ft employee's name]					
	I -	e Path Director's					
	l	r of the Life Paths unit					
	-	nt #82] resides[Life					
	·	replied yes and that					
	-	had told her 5 men					
		lcroft employee] said					
		t [Resident #82] told					
		ar it varied in the					
	number of male	es involved."					
	l '	an undated facility					
		I "[Resident #82's					
	_	", which was provided					
	1	trator on 7/6/12 at 9:30					
	a.m., indicated	the following:					
	 "6/20/12 [name	al I PN noticed					
	_	sitting in hallway [sic]					
	-	er eye. [Employee					
	willi a leai al II	ei eye. [Lilipioyee					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 13 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155066	B. WIN			07/11/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
EDGEW/	ATER WOODS				MADISON AVE SON, IN 46011	
					3011, 111 400 11	T
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		es if she was ok and	+	0		3.112
	-	, 'I need to talk to				
	someone.' [Employee name] assisted					
	_	om and asked resident				
		pset'5 men came into				
	_	.(showed the sign for				
	_	Vriter asked resident to				
	,	ould get [Name of Life				
	Path Director]					
	"6/20/12, [Life Path Director] came to					
	_	ith resident regarding				
	•	rried white men came				
	into her room tl	ne previous day and				
	had sex with he	er. Stated one of the				
	men was old a	nd the others were				
	younger."					
	"6/21/12, 9am,	Resident saw Hillcroft				
	repstated to h	ner at that time, 'I was				
	raped the other	day by a fat white				
	haired married	man.'feared resident				
	wanted to harm	n herself." Life Path				
	Director made	aware of allegation.				
	_	xecutive Director/				
	_	made aware at 4:30				
		ible made to ISDH				
	[and] Andersor	•				
		nd BDDS office. This				
	•	ddescription of male				
	· •	as a male wearing				
	green shirt and	blu (sic) pants."				
	4) During c 7/	6/12 10:00 0 ~				
ı	// uring a //	6/12, 10:00 a.m.,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 14 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 07/11/2012	
NAME OF PROVIDER OR SUPPLIER EDGEWATER WOODS		180	EET ADDRESS, CITY, STAT 19 N MADISON AVE DERSON, IN 46011	E, ZIP CODE		
EDGEWATER WOODS (X4) ID SUMMARY STEACH DEFICIENCY REGULATORY OR interview the Act the following: a.) The first 6/2 was not treated abuse and the act followed and respond to the act that the resident delusional thou of false allegation nature of the all counted as credible.) The completin involving the introduced as sees when the sees of t	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Idministrator indicated 0/12 reported event as an allegation of abuse protocol ported to ISDH Illegation was fantastic ality." Due to the fact at had a history of ght and a past history ons and the fanciful legation it was not ditable.	STR 180	9 N MADISON AVE DERSON, IN 46011 PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED	IN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
and Procedure'	Investigation Policy ', which was provided rator on 7/6/12 at 9:30 the following:					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/11/2012
	PROVIDER OR SUPPLIE	R	1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		e-includes but is not ual harassment, sexual xual assault."			
	report all unus include abuse,				
	Department of Intake form incommendation of abuse to Reat 10:11 a.m. the alleged even 6/19/12 and the	he Indiana State Health Self Reported dicated the facility reported an allegation esident #82 on 6/25/12 The report indicated ent had occurred e facility had been llegation since 6/20/12.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 16 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155066	B. WIN			07/11/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				MADISON AVE		
EDGEWA	ATER WOODS				RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on intervreview the facili implement the facili implement the prohibition protowho met the cri investigation. (Findings Included) 1.) Resident #87 Resident #82's included, but we mental retardated disorder, hallund depressive discontentials.	MENT ABUSE/NEGLECT, develop and implement nd procedures that prohibit eglect, and abuse of sappropriation of resident view and record, ity failed to promptly facility's abuse ocol for 1 of 1 resident iteria for abuse Resident #82) e: 82's record was 10/12 at 1:17 p.m. current diagnoses ere not limited to, ion, psychotic cinations and order.	F02	TAG	CROSS-REFERENCED TO THE APPROPRIAT		
	Resident #82 h	ad a 6/20/12, 2:12			of abuse to their immediate		
	p.m., Resident	·			supervisor. The Executive Director		
	l •	indicated "Resident			and/or Director of Nursing Services		
	, ,				is notified immediately and		
		odes of delusional			Executive Director reviews to assure	<u> </u>	
	_	lent stated that 5 white			reporting to all the appropriate		
		ame into her room			agencies is initiated per ISDH		
		(3:00 p.m.) and			guidelines. All allegations of Abuse,		
	touched her. C	one of the men was old			Neglect, and Misappropriation will		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 17 of 46

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155066	B. WIN			07/11/2012
NAME OF P	DOMINED OF CLIRBITES			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	PROVIDER OR SUPPLIER	•		1809 N	MADISON AVE	
EDGEWA	ATER WOODS			ANDER	SON, IN 46011	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE
		e younger. Resident			also be reviewed by the IDT to	
	was reassured that she was safe.				assure proper reporting is completed. Physician and Family ar	
		out in the unit at 3p			notified for all allegations of abuse.	
		did not see a group of			D. The Abuse Prohibition and	
	unfamiliar men	on the unit. Resident			Investigation CQI tool will be utilize	d
	was upset toda	y because she was			by facility to monitor compliance to	
	not able to go	on a [name] outing.			the Abuse Prohibition policy weekly	
	This could attri	bute to resident [sic]			for 4 weeks, then monthly for 3	
	delusional think	king. Resident has			months, and quarterly thereafter.	
	behavior care p	olan regarding			The QIS "Abuse" section questions	
	delusional epis	odes."			will be utilized to assure compliance	
	,				weekly for 4 weeks, then monthly	
	6/21/12. 9:36 a	.m., R.P.N., "Resident			for 2 months and quarterly	
		ts this morning that			thereafter. The results of the Abuse Prohibition and Investigation CQI	
		e wanted to perform a			tool and the QIS questions will be	
		tResident seen by			added to the agenda of the monthly	,
		resident placed on 15			CQI meeting for review. The CQI	
	min checks for	-			team will create a further plan of	
	I IIIII CHECKS IOI	72 Hours.			action if further issues arise or a	
	6/22/12 1:26 5	m DDN "IDT			threshold score of 100% is not	
		.m., R.P.N., "IDT			achieved on Abuse Prohibition and	
		ary Team]: SSD [Social			Investigation CQI tool.	
		tor], DNS [Director of			E. 8-6-2012	
	_	es], ADNS [Assistant				
		sing] and LPD [Life				
	Path Director]:					
		Hillcroft [Provider for				
		elopmentally disabled				
		resentative on 6/21/12				
	stating that res	ident made statement				
	(sic) that a mal	e made inappropriate				
	contact with he	r and resident felt like				
	she wanted to	harm herselfThe				
	resident reporte	ed it was an older fat				
	-	hair. This writer				
		lent if this was the				
1			I			1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 18 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155066	B. WING		·	07/11/	2012
NAME OF I	PROVIDER OR SUPPLIE		STRI	EET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIE	N.	180	9 N	MADISON AVE		
EDGEWA	ATER WOODS		ANI	DER	SON, IN 46011		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	same incident	that we talked about					
	yesterday. Re	sident stated yes.					
	Resident state	d she is familiar with					
	residents in the	e facility and it is not a					
		facilitybelieved					
	male to have v						
	maintenance of	lepartment, however					
	the description	of such man is not					
	consistent with	any male working at					
	this facility."						
	6/25/12, 8:00 p	o.m., R.P.N.,"received					
	report that was	s sent to ISDH [Indiana					
	State Departm	ent of Health] from					
	OBRA provide	r [Hillcroft]. This report					
	incident has va	ariances from issue that					
	resident discus	ssed with staff thus this					
	SW [Social Wo	orker] interviewed					
	resident about	incident reported by					
	OBRA provide	rResident,'some					
	guys came in r	my room.''They took					
	off my clothes	and did it to me.'					
		x.''I told her. And she					
	1	After said report was					
		resident's name] and					
		viewed SW has					
	founded (sic) t	his issue reported by					
	` ′	er) to be same incident					
		ff on 6/20/12 and to					
	· ·	r on 6/21/12, however					
		arying accounts of					
	information ab						
	2.) Review of	a document titled					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 19 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155066	B. WIN			07/11/2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
EDCE/M	ATED WOODS				MADISON AVE	
EDGEW	ATER WOODS			ANDER	SON, IN 46011	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	BEIGHNOT	DATE
		Event-Verification of				
	Immediate Protective Measures Required" indicated the report was					
	1 '					
	1	22/12, at 2:52 p.m. to				
		Director by the Bureau				
	of Developmen					
	-	S). The document				
	indicated:					
	"Diago angura	that immediate				
	"Please ensure that immediate protective measures are in place."					
	protective mea	sures are in place.				
	"[Decident #82]] reported to [Hillcroft				
	_ ·	that she had been				
	l .					
	1 .	day (6/19/12) around ernoon. She said the				
		vas an employee with I described him as a				
	•	n gray hair who was				
		en shirt and blue				
	"	oft employee's name]				
	I	e Path Director's				
	I -	r of the Life Paths unit				
	_	nt #82] resides[Life				
	_	replied yes and that				
	l	had told her 5 men lcroft employee] said				
	I	t [Resident #82] told				
		ar it varied in the				
	number of male					
		co ilivuiveu.				
	 "Plan to Resolu	ve: Hillcroft has				
		reporting procedures,				
		I police and completed				
		ate Department of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 20 of 46

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066			LDING	NSTRUCTION 00	(X3) DATE COMPI 07/11	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE	
	, ,	Incident Report Form : Suspicion of a Crime Ident."						
	document titled name] timeline	an undated facility I "[Resident #82's ', which was provided trator on 7/6/12 at 9:30 the following:						
	with a tear at h name] asked re resident stated someone.' [Em her into her roo why she was u my room and intercourse). V	sitting in hallway (sic) er eye. [Employee es if she was ok and , 'I need to talk to ployee name] assisted em and asked resident pset'5 men came into .(showed the sign for Vriter asked resident to ould get [Name of Life						
	room, spoke wi incident5 mal into her room the had sex with he men was old all youngerplace charting for del	Path Director] came to th resident regarding ried white men came ne previous day and er. Stated one of the nd the others were sed resident on hot usional thinkingd/t dx sorder with delusions."						
	"6/21/12, 9am,	Resident saw Hillcroft						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 21 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155066	B. WIN	_		07/11/2	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
EDGEW/	ATER WOODS				MADISON AVE SON, IN 46011		
					3011, 111 40011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
1110		her at that time, 'I was	+	0			BIIIE
		·					
	raped the other day by a fat white haired married man.'feared resident						
		n herself." Life Path					
	Director made aware of allegation.						
	Director made	aware or anogation.					
	 "6/25/12-ED	executive Director/					
	-	made aware at 4:30					
	_	able made to ISDH					
	[and] Andersor						
		ind BDDS office. This					
	report revieweddescription of male						
	-	as a male wearing					
		l blu (sic) pants."					
		(/					
	"6/29/12And	lerson PD came in,					
		plan, or investigation					
		history and closed					
	police investiga	•					
	4.) During a 7/	/6/12, 10:00 a.m.,					
	interview the A	dministrator indicated					
	the following:						
	a.) The first 6/2	20/12 reported event					
	was not treated	d as an allegation of					
	abuse and the	abuse protocol					
	followed and re	eported to ISDH					
	because " the a	allegation was fantastic					
	not based in re	ality." Due to the fact					
	that the resider	nt had a history of					
	delusional thou	ight and a past history					
	of false allegati	ions and the fanciful					
	nature of the al	llegation it was not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 22 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155066	B. WIN			07/11/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
	. TED WOODO				MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	counted as cre	ditable.					
	the OBRA prov was more cred abuse protocol	25/12 information by rider, the allegation itable and the facility was then initiated.					
	involving the in	terviews or					
	assessments o	f all residents on the					
	Life Path Unit of	did not occur until					
	6/25/12 and the	e reporting to the					
	Indiana state D	epartment of Health of					
	_	f abuse did not occur					
	until 6/25/12.						
	all allegations of	acility policy to report of abuse to ISDH and allegations of abuse.					
	facility policy tit Reporting, and and Procedure	current, 2/2010, led "Abuse Prohibition, Investigation Policy ", which was provided trator on 7/6/12 at 9:30 the following:					
		includes but is not al harassment, sexual assault."					
	report all unusu	Director/designee will ual occurrences, which within 24 hours of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 23 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155066			(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 07/11/	ETED	
	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	discovery, to the Division of the Department of							
	Department of Intake form ind Administrator nof abuse to Reat 10:11 a.m. the alleged even 6/19/12 and the	ne Indiana State Health Self Reported icated the facility eported an allegation sident #82 on 6/25/12 The report indicated ent had occurred e facility had been legation since 6/20/12.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 24 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155066	B. WIN			07/11/	2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			1809 N	MADISON AVE		
	ATER WOODS				RSON, IN 46011		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
F0253 SS=B	SERVICES The facility must maintenance ser	G & MAINTENANCE provide housekeeping and vices necessary to maintain ly, and comfortable interior.					
			F02	53	A. Resident Rooms and		08/06/2012
	facility failed to resident rooms bathrooms,(Ro 108, 113, and 1	including oms 101, 106, 110, 107) and 1 of 3 oors were in good			bathrooms 101, 106, 107, 108, 110, and 113 were cleaned, sanitized, and paint was touched up immediately during survey. The Life Path Shower room was cleaned and sanitized. B. All resident rooms and bathrooms were cleaned, sanitized, and reviewed for repair during		
	Finding include	:			survey. The remaining shower rooms were also cleaned and sanitized.		
		2 and 7/3/12, the bserved in the listed :			C. Facility Maintenance Staff including supervisor received inservice training on 7-27-12 by the Executive Director regarding routine	<u>.</u>	
	right had 2 larg paint 12 inches brown staining	e bathroom wall to the e areas of chipped up from floor and around the toilet base staining on the faucet.			maintenance expectation for resident rooms and common areas including shower rooms. Housekeeping Staff including supervisor received inservice training on 7-27-12 by Executive Director regarding housekeeping		
	right of the doo chipped and ma approximately the floor. The i bathroom door	12-18 inches up from nterior side of the had scuffing the width roximately 12 inches			expectations for patient rooms and common areas including shower rooms. D. Maintenance of sanitary, orderly, and comfortable conditions will be monitored by through use of Housekeeping Procedure's "Daily Housekeeping", "Restroom Cleaning", and "Detail Cleaning" checklists. The "Daily		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 25 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	TED
		155066	B. WIN			07/11/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1			
					MADISON AVE		
EDGEW/	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					Housekeeping" checklist will be		
	Doom 110: Th	e left wall had marring			completed on 10 resident rooms an	d	
		_			1 shower room daily by the	<u> </u>	
	and black marking 3-3 1/2 feet up the				Housekeeping Supervisor for 4		
	wall 6-7 feet wide and 4 inches deep.				weeks, then weekly for 1 month by		
	The cove boar	d to the left of the			the Executive Director, then monthl	,	
	bathroom door	was pulling away from				У	
					for 2 months by the Executive		
	the wall. The air conditioner vent was out of place. The cove base around				Director, then quarterly thereafter		
	•				utilizing the Physical Environment		
		loor was pulling away			CQI. Additionally, the Room Readiness Checklist will be		
	and down in one spot along the entire						
	wall.				completed by the Maintenance		
					Supervisor on 10 rooms and 1		
	Room 108. Th	ere was brown staining			shower room daily for 4 weeks, the		
		I the bathroom toilet			weekly for 1 month by the Executive	e	
		the bathloom tollet			Director, and then monthly for 3		
					months by the Executive Director,		
		e corner of the wall by			then quarterly thereafter utilizing		
	the bathroom h	nad marred and			the Physical Environment CQI. The		
	chipped dry wa	all and the cove board			CQI team will develop further action		
		was pushed in the			plans should threshold score of 90%	5	
	width of 1 1/2 t				not be achieved.		
	WIGHT OF 1 1/2 (iie.			E. 8-6-2012		
	Doom 107: Th	ara waa O araaa af					
		ere was 2 areas of					
		I the toilet and hard					
	water build up	on the faucet.					
			İ				
	2 \ During an	anvironmental tour on					
	, ,	environmental tour on					
	7/6/12 at 10:00	· ·					
	Maintenance S	Supervisor and					
	Housekeeping	Supervisor, the Life					
		hower room was					
	observed to have a white tile floor.						
	_	e floor was noted to be					
	discolored thro	ughout the room. The					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155066 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE COMPI 07/11	LETED
	PROVIDER OR SUPPLIER ATER WOODS	1809 N	ADDRESS, CITY, STATE, ZIP COI MADISON AVE RSON, IN 46011	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	discoloration was in shades of black, gray and white.				
	During a 7/6/12 at 11:30 a.m., interview with the Housekeeping Supervisor, she indicated there was no policy for cleaning the gout in the tile floor. The Supervisor indicated the facility does deep clean the floor once a month and does so using the instructions in the training manual for floor care. The Housekeeping Supervisor also indicated she has talked to the corporation about getting different chemicals to clean the tile floors. 3.1-19(f)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 27 of 46

STATEMEN	T OF DEFICIENCIES	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155066	B. WING	3		07/11/	2012
	PROVIDER OR SUPPLIER			1809 N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0329 SS=D	UNNECESSARY Each resident's of from unnecessar drug is any drug dose (including of excessive duration monitoring; or wifor its use; or in the consequences with should be reduced combinations of the same of the	drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate thout adequate indications the presence of adverse which indicate the dose ed or discontinued; or any the reasons above. In the presence of adverse which indicate the dose ed or discontinued; or any the reasons above. In the presence of adverse which indicate the dose ed or discontinued; or any the reasons above. In the reasons above assessment of a lity must ensure that ave not used antipsychotic en these drugs unless and the clinical record; and se antipsychotic drugs dose reductions, and entions, unless clinically in an effort to discontinue In the view and record lity failed to ensure a pot started on a routine medication without first enchemical interventions and an assessment of the end possible causes beances were and for the presidents indecessary.	F032	29	A. Resident 10's attending physician was contacted to review the order for routine hypnotic (Ambien 10mg). Physician changed the order from routine to PRN. Non-chemical interventions for Resident 10 were put into place to assure no unnecessary doses are administered. Resident 10 is adequately monitored for use of hypnotic medication. B. All residents have the potential to be affected by this deficient practice. The clinical records of resident receiving		08/06/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 28 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155066		LDING		07/11/	2012
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
ED OF W	. TED WOODO				MADISON AVE		
EDGEWA	ATER WOODS			ANDER	RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings Includ	le:			hypnotics medications have been	•	
					reviewed to ensure the medications	5	
					are medically necessary. The audit		
	Desident #10's	record was reviewed			included care plan, C.N.A need		
					sheet, behavior monitoring form for	r	
	on 7/10/12 at 2:30 p.m.				appropriate interventions. All staff		
					were provided inservice training on		
	Resident #10 v	vas admitted to the			7-17-12 by SDC regarding the use of	F	
	facility on 3/30/	/12.			non-pharmacological interventions		
	,				and alternatives to the use of		
	Resident #10's	current and admission			hypnotics		
		uded, but were not			C. All staff were provided		
	_				inservice training on 7-17-12 by SDC	2	
	•	pecific psychosis,			regarding the use of		
	I	r, adjustment disorder			non-pharmacological interventions		
	1	abetes mellitus,			and alternatives to the use of		
	depression and	d dementia.			hypnotics. The psychotropic		
					medication management program		
	At the time of a	admission Resident #10			was reviewed with licensed nurses		
	did not have or	ders for a			by the Director of Social Services or		
		aiding medication.			designee. Residents exhibiting		
		ident #10's orders from			symptoms of insomnia are discussed	d	
					daily in IDT meeting. This will ensure	e	
		irsing home placement			that appropriate		
	indicated he wa	•			non-pharmaceutical interventions		
	hypnotic while	residing in that facility.			are in place and monitoring is		
					initiated. All new orders for		
	Resident #10 h	nad a 4/8/12, one time			hypnotics will be reviewed daily at		
	order for Ambie	en 10 mg (a hypnotic or			morning meeting to ensure		
		edication) today at			hypnotics are ordered only as		
	bedside.	carearier, ready at			needed and that		
	Deadide.				non-pharmacological interventions		
	B : 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				are in place, utilized, and		
	Resident #10 had a current, 4/13/12,				documented prior to medication		
	physician's order for Ambien 10 mg (a				administration.		
	hypnotic or slee	ep aiding medication)			D. The Psychoactive/Behavior		
	daily at bedtime	e for insomnia. This			Management CQI tool will be		
	order continued	d to be in place on			utilized weekly for 1 month, then		
	7/10/12.	·			monthly for 3 months then quarterl	У	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 29 of 46

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 07/11/	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN 46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Notes (R.P.N.) following docur sleep: a.) 4/2/12, 4:58 "excessive use most of shift." b.) 4/8/12, 8:52 [resident] has a up all night [and c.) 4/10/12, 2:4"repetitive ca through out this at a time.' d.) 4/13/12, 6: "Resident awal asking 'what tir repositioning not president] just refer to a different option name] sleep be is requesting sleep be in the resident sleep be in the r	of call light, awake 2 p.m., R.P.N., "res a hx [history] of staying d] not sleeping." 46 a.m., R.P.N., Il light use, awake s shift with short naps 14 a.m., R.P.N., ke all noct, [night] ne is it', tried umerous times, Res olled on his back.' 57 a.m., R.P.N., "IDT try Team] discussed s to help [resident's etter at nightnursing eep aid."		thereafter. The CQI team will review data. If the threshold of 90% compliance is not met then an action plan will be developed and monthly audits continued. New orders for hypnotics along with other psychotropic medications will be reviewed monthly for 3 months and then quarterly as part of the monthly CQI meeting. Each resider utilizing these medications will have their non-pharmaceutical interventions reviewed monthly for 3 months and then quarterly as part of CQI. E. 8-6-2012	l nt e	
	was anowed th	C opportunity to be up				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 30 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155066	B. WIN	G		07/11/	/2012
NAME OF I			_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIEF	C		1809 N	MADISON AVE		
EDGEW/	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	out of hed whe	n he was awake.					
	out of bea wife	Title was awake.					
	h) Documents	ation if Resident #10					
	l '						
		p at night or would					
	prefer to sleep	at another time.					
	c.) Documentation Resident #10 was						
		ther causative factors					
		upting sleep such as					
	light, noise, ten	nperature, excess					
	consumption of	f caffeine, etc.					
	d.) Documenta	ation of the resident					
	having sleep di	isturbances other than					
	the above four						
	e.) Documenta	ation that other					
	l '	nterventions other than					
		ad been attempted					
		oduction of a sleep aid,					
	l -	ubs, warm milk, soft					
	i iliusic, paili as:	sessments, etc.					
	D	12 2:05					
	During a 7/10/1						
	· ·	Social Service Director					
		other than offering					
		o other non-chemical					
	interventions h	ad been documented					
	as attempted p	rior to placing the					
	resident on a ro	outine hypnotic					
	medication. Sh						
		dent #10 had not been					
		needed sleep aid which					
		st on nights he felt he					
	•						
	Logia not sieep	o. She indicated an					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 31 of 46

	of correction identification number: 155066	A. BUILDING B. WING	COMP	COMPLETED 07/11/2012	
	PROVIDER OR SUPPLIER ATER WOODS	1809 N I	DDRESS, CITY, STATE, ZIP COD MADISON AVE SON, IN 46011	Е	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	assessment had not been completed to determine if Resident #10 was a night time sleeper or preferred to sleep at other times of the day and be awake at night. She also indicated there was no documentation of an assessment to ensure other reasons for the residents sleep disturbance had been ruled out. Review of a current, undated, facility policy titled "ASC [American Senior Communities] Psychotropic Medication Management Program", which was provided by the R.N. Consultant on 7/10/12 at 4:20 p.m., indicated the following: "Sedative/Hypnotics must have a diagnoses of insomnia or sleep disorder. There should also be evidence that other reasons for sleep disturbance have been ruled out." 3.1-48(b)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 32 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155066	B. WING			07/11/	2012
NAME OF B	NOVADED OD GUDDI IED		_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1809 N	MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0425 SS=E	483.60(a),(b) PHARMACEUTI PROCEDURES, The facility must emergency drug- residents, or obta agreement descripart. The facility personnel to adm permits, but only supervision of a A facility must pr services (including the accurate acquested and administering biologicals) to merceident. The facility must pr services of a lice provides consultated provides consultated provision of phare Based on reconsinterview, the farmedications were administration from the medication revious (Resident # 94). Findings including the reviewed on 7/9.	CAL SVC - ACCURATE RPH provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed minister drugs if State law under the general licensed nurse. Fovide pharmaceutical may procedures that assure quiring, receiving, dispensing, g of all drugs and leet the needs of each lemploy or obtain the ensed pharmacist who ation on all aspects of the emacy services in the facility. For dreview and facility failed to ensure lever available for for 4 of 10 resident liews in a sample of 10. (17, 60, and 75) The ensemble of the ens	F04:		A. The Physicians of residents 947, 60, and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure that all current medications were available for administration. B. All residents have the potential to be affected by this deficient practice. The facility completed an audit of the MAR for the residents who reside in the facility to assure that all current		08/06/2012
	· ·				medications and dosages were available for administration. C. Inservice training was provided by the SDC on 7-17-12 on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet Page 33 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	DDIC	00	COMPL	ETED
		155066	A. BUII B. WIN			07/11/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
EDCEW.	ATER WOODS				MADISON AVE		
EDGEW	ATER WOODS			ANDER	RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pharmacy.				the policy and procedure for		
					handling "medication not		
	The nursing no	tes between the above			available/no supply" and		
	_	ddress the medication			documentation including but not		
					limited to: notification of physician,		
	being unavaila				notification of resident/family,		
	physician was notified.				notification of DNS/designee, and		
	Additional information was a superior				communication with the pharmacy.		
	Additional information was requested				In the event that medication is not		
	from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding the medication				available licensed staff will attempt		
					to locate the medication, they will		
					check the Emergency Drug Kit (EDK))	
	unavailability.				for the med. If still unavailable,		
	diavanasinty.				licensed staff will then contact the		
	During interview	w on 7/10/12 of 4 n m			pharmacy for stat delivery. Staff wi	II	
		w on 7/10/12 at 4 p.m.,			contact the physician, the		
		cated she was unable			resident/family, and the		
	1	formation regarding			DNS/designee. Licensed staff will		
	the above Pep	cid not being available			complete a Medication/Treatment		
	for administrati	on.			Error Report to document and track	(
					the event. MAR audits will be		
	2. The record	for Resident # 7 was			conducted daily by the		
	reviewed on 7/	6/12 at 8:46 a.m.			DNS/designee to assure meds are		
	TOVIOUGU GIT TY	0/12 dt 0.10 d.m.			available and physicians are notified		
	The lune 2012	MAR indicated			Those audits will be done daily for		
					consecutive weeks utilizing the MAI		
		azide (HCTZ) 25 mg			Checklist. Those audits will continu to be done weekly for 4 additional	е	
		ole on June 20, 21 and			weeks, then monthly for 2 months,		
	22 for administ	ration.			and quarterly thereafter.		
					D. The MAR CQI tool will be		
	The nursing no	tes between 6/20-6/22			completed weekly for 4 weeks, the	า	
	did not address	s the HCTZ not being			monthly for 2 additional months,		
		at the physician was			then quarterly thereafter. The		
	notified of the r				results of both audits and the		
					Medication/Treatment Error Report	ts	
	Additional infa-	mation was requested			will be added to the agenda of the		
		mation was requested			monthly CQI meeting for review.		
		ant Director of Nursing			The CQI team will create a further		
	I (ADON) on 7/1	0/12 at 10:35 a.m	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155066	B. WING		07/11/2012
NAME OF F	PROVIDER OR SUPPLIE	ER.	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				N MADISON AVE	
EDGEW/	ATER WOODS		ANDE	RSON, IN 46011	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	DATE
	regarding the	medication		plan of action if further issues aris	
	unavailability.			achieved on MAR CQI tool.	•
	During interview on 7/10/12 at 4 p.m.,			E. 8-6-2012	
		•			
	the ADON indicated she was unable				
	to locate any information regarding the above HCTZ not being available				
	for administrat	LIOII.			
	2 The recent	for Decident # 60 was			
	3. The record for Resident # 60 was reviewed on 7/10/12 at 8:20 a.m.				
	The April 2012	2 MAR indicated			
	-	./20, Risperdal 0.25 mg			
		mg was not available			
	for administrat	•			
	ioi auriiinistrat	uon.			
	 The May 2012	2 MAR indicated			
		5/6, Zegerid 40/100 mg			
		able for administration.			
	.745 1151 4 4 4 114				
	The June 2013	2 MAR between			
		icated Zanaflex 5 mg			
	was not availa				
		-			
	The nursing no	otes, dated 4/12/11,			
	_	family was notified of			
		nem to bring in the			
		dication. No other			
	documentation	n for April indicated the			
	family was notified again or any other attempt was made to obtain the residents medication,				
		,			
	On 5/11/12 at	2:41 p.m., the nursing			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 35 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155066	B. WIN	G		07/11/	/2012
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		-			MADISON AVE		
EDGEWA	ATER WOODS			ANDER	SON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	notes indicated	I the resident's					
	girlfriend was c	contacted about his					
medication renewals and she stated							
	she would order his medications from						
	the pharmacy of	on this date.					
	On 6/22/12, the	e nursing notes					
	indicated the fa	amily was notified to					
	pick up the res	ident's needed					
	medications.						
	Additional information was requested						
	from the Assist	ant Director of Nursing					
	(ADON) on 7/1	0/12 at 10:35 a.m.,					
	regarding the n						
	unavailability.						
	,						
	During interviev	w on 7/10/12 at 10:58					
	a.m., the ADO						
	· ·	med the facility the					
	l '	ordered at a dose that					
		she had personally					
		urse Practitioner and					
		changed on 6/22/12					
		se given on 6/23/12.					
		50 givon on 0/20/12.					
	During interviev	w on 7/10/12 at 4 p.m.,					
	•	cated she was unable					
		hysician notification of					
		t getting the above					
		She indicated there was					
		that the family was					
		not bring in the					
	medication.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 36 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/11/2012	
	PROVIDER OR SUPPLIE	R	1809 N	ADDRESS, CITY, STATE, ZIP CODE I MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	7/11/12 at 1:40 a medication with the reason was back of the MA was unavailabed the pharmacy indicated the pharmacy indicated the pharmacy indicated when a given. She also had some diffirmediations time. Quality Improved at 2:15 p.m., we were many how MARS. An instinct indicated "If (medication) on the modern of the many how how how many how	•			
	included, but v history of CVA accident/stroke behaviors, anx	s current diagnoses were not limited to, a (cerebral vascular e), dementia with tiety, depression, sease, anemia,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 37 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CC A. BUILDING B. WING	00	COME	E SURVEY PLETED 1/2012	
NAME OF PROVIDER OR SUPPLIER EDGEWATER WOODS			STREET A 1809 N	ADDRESS, CITY, STATE, ZIP CO MADISON AVE SSON, IN 46011	DE	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR diabetes mellitu gastro-esophog seizure disorde A review of Res Medication Adr July (1-10), Jur medications we following dates a.) 6/3/12-Ultra	ministration Record for ne and May 2012 found ere not available on the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPENCION OF THE PROPERTY OF THE PROVIDENCE OF T	ULD BE	(X5) COMPLETION DATE
	b.) 6/26/12- Za	antac (a medication to ch acid or stomach				
	d.) 5/7/12, 8:00 medication to a or stomach ups available-"phare.) 5/8/12, 8:00 available "phare.) During a 7/11/1 interview the Dindicated the far experiencing a	macy notified" D a.m Pepcid not macy notified" 12, 10:00 a.m., irector of Nursing				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 38 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY PLETED 1/2012		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE					
EDGEWA	ATER WOODS			RSON, IN 46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	3.1-25(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 39 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COM			COMPL	ETED	
		155066	B. WIN			07/11/	2012
			D. (VII)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				MADISON AVE		
EDGEWA	ATER WOODS				RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	1		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
F0465	483.70(h)	,					
SS=C	` '	NAL/SANITARY/COMFORT					
	ABLE ENVIRON						
		provide a safe, functional,					
	•	mfortable environment for					
	residents, staff a	·					
	Based on obse	rvation, the facility	F04	65	A. The medication rooms on		08/06/2012
	failed to ensure	e 2 of 2 medication			Golden Orchard and Life Path were		
	rooms were cle	an. This deficient			cleaned and sanitized and paint was		
	practice had the	e potential to impact			touched up immediately during		
	76 of 76 reside	nts.			survey. B. All residents have the		
					potential to be affected by this		
	Finding include	:			delinquent practice. The medication	1	
		•			rooms on Golden Orchard and Life		
	On 7/6/12 at 9 [.]	27 a.m., during an			Path were cleaned and sanitized and	d	
		h LPN # 11 in the			paint was touched up immediately		
		d and Moving Forward			during survey. Both Medication		
		m, the following was			Rooms had counter top, sink, and		
		sink was discolored			faucet fixtures replaced. A new		
		had lime build-up. The			backsplash was installed. Walls		
	countertop was	·			were refinished and painted. Cove		
	•				base was repaired or replaced in		
		missing caulking			both Medication storage rooms. C. Facility Maintenance Staff		
		I. The wall opposite			including supervisor received		
	_	nad scuffed and			inservice training regarding routine		
	marred paint ar	•			maintenance expectation for		
		5 feet in width and 6			medication storage areas. All staff		
	inches in length	٦.			received inservice training 7-27-12		
					by the Executive Director regarding		
	_	ervation of the Life Path			how to alert Maintenance		
		m with LPN # 12, the			Department to needed repairs.		
	floor around the	e cove board had a			D. The Medication Storage		
	build-up of dirt	and debris and the			rooms will be inspected visually by the Director of Maintenance weekly		
	sink and faucet	had a build-up of hard			for 4 weeks. The Medication		
	water stains.				Storage Rooms will be inspected		
					visually by the Executive Director		
	3.1-19(f)				weekly for 1 month then monthly		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 40 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 07/11/2012			
	ROVIDER OR SUPPLIEI TER WOODS	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				for 3 months, then quarterly thereafter utilizing the Physical Environment CQI. If the ED rounds threshold of 90% compliance is no met, the CQI team will develop further action plan to address. E. 8-6-2012	5			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 41 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE		
		155066	B. WING		07/11/2012
NAME OF PROVIDER OR SUPPLIER EDGEWATER WOODS			1809	T ADDRESS, CITY, STATE, ZIP CODE N MADISON AVE ERSON, IN 46011	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0520 SS=E	QUARTERLY/PL A facility must mand assurance condinector of nursing	aintain a quality assessment ommittee consisting of the g services; a physician e facility; and at least 3 other			
	committee meets issues with respenses assessment and necessary; and committee meets	ssment and assurance s at least quarterly to identify ect to which quality assurance activities are develops and implements s of action to correct deficiencies.			
	disclosure of the except insofar as the compliance or requirements of Good faith attemidentify and corre	ecretary may not require records of such committee s such disclosure is related to of such committee with the this section. pts by the committee to ect quality deficiencies will basis for sanctions.			
	Based on interverview, the facion effective pla medication ava	view and record lity failed to implement n of action to address ilability. This deficient ed Residents # 94, 7,	F0520	A. The CQI Committee addresse and will continue to address issues related to Medication Availability. The Physicians of residents 94, 7, 60 and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure tha	,
	•	e: 2, 12:55 p.m., the nd the Director of		all current medications were available for administration. B. The CQI Committee addresse and will continue to address issues related to Medication Availability.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 42 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			ETED	
		155066	B. WIN			07/11/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	R			MADISON AVE		
EDGEW/	ATER WOODS				RSON, IN 46011		
LDGLW	ATER WOODS			ANDLIN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Nursing were in	nterviewed regarding			All residents have the potential to		
	the QAA Comr	nittee identifying and			be affected by this deficient		
	developing a p	lan to address			practice. The facility completed an		
	availability of m	nedications and the			audit of the MAR for the residents		
	following conce				who reside in the facility to assure		
	l lone willing contex	311.61			that all current medications and		
	a) The record	for Resident # 94 was			dosages were available for		
	,				administration.		
	reviewed on 7/	9/12 at 2:05 p.m.			C. The CQI committee continues	5	
					to address through action plan		
	The May 2012	Medication			issues and concerns identified by		
	Administration	Record (MAR)			benchmarking scores within its CQI		
	indicated Pepc	id 20 milligrams (mg)			process, and specifically Medication		
	was not availal	ole 5/17-5/21 from the			Availability. Inservice training was provided by the SDC on 7-17-12 on		
	pharmacy.				the policy and procedure for		
	p				handling "medication not		
	During interview	w on 7/10/12 at 4 p.m.,			available/no supply" and		
	•	cated she was unable			documentation including but not		
					limited to: notification of physician,		
	_	formation regarding			notification of resident/family,		
	•	being available for			notification of DNS/designee, and		
	administration.				communication with the pharmacy.		
					In the event that medication is not		
	b.) The record	for Resident # 7 was			available licensed staff will attempt		
	reviewed on 7/	6/12 at 8:46 a.m.			to locate the medication, they will		
					check the Emergency Drug Kit (EDK)		
	The June 2012	MAR indicated			for the med. If still unavailable,		
		azide (HCTZ) 25 mg			licensed staff will then contact the		
	_	ole on June 20, 21 and			pharmacy for stat delivery. Staff wi	II	
		· ·			contact the physician, the		
	22 for administ	ialiuii.			resident/family, and the		
					DNS/designee. Licensed staff will		
	•	w on 7/10/12 at 4 p.m.,			complete a Medication/Treatment		
	the ADON indic	cated she was unable			Error Report to document and track		
	to locate any ir	formation regarding			the event. MAR audits will be		
	the HCTZ not b	peing available for			conducted daily by the		
	administration.	-			DNS/designee to assure meds are		
					available and physicians are notified	1.	
			1		I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 43 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	I DING	00	COMPLE	ETED
		155066	A. BUILDING B. WING 07/11			07/11/2	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
EDOE!W	ATER WOODS				MADISON AVE		
EDGEW	ATER WOODS			ANDER	RSON, IN 46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	c.) The record	for Resident # 60 was			Those audits will be done daily for	4	
	reviewed on 7/	10/12 at 8:20 a.m.			consecutive weeks utilizing the MAI	₹	
					Checklist. Those audits will continu	e	
	The April 2012	MAR indicated			to be done weekly for 4 additional		
	· ·				weeks, then monthly for 2 months,		
		20, Risperdal 0.25 mg			and quarterly thereafter.		
		mg was not available			D. The MAR CQI tool will be		
	for administrati	on.			completed weekly for 4 weeks, ther	n	
					monthly for 2 additional months,		
	The May 2012	MAR indicated			then quarterly thereafter. The		
	_	6, Zegerid 40/100 mg			results of both audits and the		
		ole for administration.			Medication/Treatment Error Report	:s	
	was not availal	ole for darining dution.			will be added to the agenda of the		
	The lune 2010	? MAR between			monthly CQI meeting for review.		
					The CQI team will create a further		
		cated Zanaflex 5 mg			plan of action if further issues arise		
	was not availal	ole.			or a threshold score of 90% is not		
					achieved on MAR CQI tool.		
	During intervie	w on 7/10/12 at 10:58			E. 8-6-2012		
	a.m., the ADOI	N indicated the					
	•	med the facility the					
	, ,	ordered at a dose that					
		she had personally					
		urse Practitioner and					
		changed on 6/22/12					
	and the first do	se given on 6/23/12.					
	d.) Resident#	75's record was					
	· ·	10/12 at 12:53 p.m.					
	Pesident #75's	current diagnoses					
		•					
	•	vere not limited to, a					
	_	(cerebral vascular					
	accident/stroke	e), dementia with					
	behaviors, anx	iety, depression,					
	Alzheimer's dis	• • •					
		us, bipolar disorder.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5Q2X11 Facility ID: 000026 If continuation sheet Page 44 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
THEFTERN	or condition	155066		LDING		07/11/	
		.0000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
NAME OF I	PROVIDER OR SUPPLIER				MADISON AVE		
EDGEWA	ATER WOODS				SON, IN 46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		geal reflux disease, er and mood disorder.					
	Seizure disorde	and mood disorder.					
	A review of Res	sident #75's					
		ninistration Record for					
		ne and May 2012 found					
	, , ,	ere not available on the					
	following dates						
	a.) 6/3/12-Ultra	am (a pain medication)					
	not available, p	harmacy aware.					
	,	antac (a medication to					
		ch acid or stomach					
	upset) not avai	lable					
	c.) 6/27/12-Zai	ntac not available					
	d.) 5/7/12.8:00	0 a.mPepcid (a					
	,	iddress stomach acid					
	or stomach ups	set) not					
	available-"phar	macy notified"					
	•	a.m Pepcid not					
	available "phar	macy notified"					
	During a 7/11/1						
		irector of Nursing					
	indicated the fa	-					
		problem regarding					
		ilability and the current					
	pharmacy.						
	During an inter	view with LPN #10 on					
	_	p.m., she indicated if					
	1/11/12 at 1.40	p.iii., one indicated ii					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 45 of 46

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/11/2012
	PROVIDER OR SUPPLIE	R	1809 N	ADDRESS, CITY, STATE, ZIP CODE I MADISON AVE RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	the reason wa back of the MA was unavailabed the pharmacy indicated the pharmacy indicated the pharmacy indicated when a given. She also had some diffirmediations time. During an interest 2:15 p.m., the indicated the Conducted the Conduction had been time. The March 20 successfully an in that medicated in the medicated i	ely. Eview on 7/11/12 at Director of Nursing QAA committee had erns with "pharmacy arch 2012 and a plan or en implemented at that			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5Q2X11

Facility ID: 000026

If continuation sheet

Page 46 of 46